Correspondence

AIDS, Autopsies, and Fear

TO THE EDITOR: Recent correspondence[1] concerning my essay "First Case"[2] questions the outlook of that piece and its appropriateness for a medical journal. The essay, as I stated in its first sentence, addresses fear. It is not a scientific discussion of the acquired immunodeficiency syndrome (AIDS). I have written scientific papers on AIDS, including articles on the safe performance of autopsies in cases of AIDS,[3-6] and on the ethical necessity to provide autopsies in cases of deaths from AIDS (Ratzan RM, Schneiderman H: "AIDS, Autopsies and Abandonment," submitted for publication). By contrast, in "First Case" I sought to explore the emotional realities of occupational exposure, to delineate the irrationalities that conflict with scientific data and published epidemiologic experience, and to focus on the means employed and psychological costs incurred in achieving an acceptable, professional performance despite severe anxiety. While such topics might interest others as well, physicians constituted the intended audience. As a profession, medicine has evolved away from a self-image of unemotional, detached comportment in accord with science alone and toward more recognition of the inevitability of feelings and the great desirability of dealing with them.

If "First Case" helped some health professionals to cope better with fear—whether of AIDS or of anything else—I have succeeded in my mission. I hope, along with Dr Geller, that it will not be misconstrued or misquoted as supporting the unethical refusal to provide any services, postmortem examination included, to AIDS patients.[7] Discussion of controversial issues always runs the risk of misinterpretation, but the solution is to provide clarity. Neither human weaknesses nor the fear of AIDS will evaporate, but both can be managed by explicit attention.

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Gas Gangrene or Anaerobic Cellulitis?

TO THE EDITOR: The article by Dennis Stevens and coworkers, "Spontaneous Gas Gangrene at a Site of Remote Injury—Localization Due to Circulating Antitoxin," in the February issue,[1] is a very interesting example of "spontaneous" clostridial infection. The demonstration of a rising antibody titre directed against θ-toxin provides an intriguing hypothesis for the localization of infection in this case. It is unfortunate, however, that the authors chose to characterize this infection as "gas gangrene." J. D. MacLennan, whose landmark article is their first reference,[2] clearly categorizes the spectrum of clostridial infections observed in human infection. He describes three stages of clostridial infection but points out that, in reality, a continuous spectrum is observed. Simple contamination is marked by clostridia growing with other bacteria in a wound with necrotic material present. There is no systemic reaction and the wound appears foul and dirty with a thin exudate. It is appropriately treated by debridement and local care without antibiotics. Anaerobic cellulitis, also termed gas abscess, is characterized by a local heavy clostridial growth without invasion. The wound is foul with brown, seropurulent discharge and abundant gas formation. There is little or no surrounding edema or systemic reaction. There is no muscle invasion. Anaerobic myonecrosis, also known as clostridial myonecrosis or "gas gangrene," is marked by local edema, a thin exudate, absence of white blood cells, no vascular hyperemia, and death of muscular tissue. Gas formation is usually scant. A profound systemic reaction, including tachycardia, hypotension, mental changes, and shock, follows if early aggressive treatment is not instituted. Dermal gangrene, bullae, and obvious gas are late findings.

The patient described by Stevens and colleagues had few systemic signs of infection, no muscle gangrene, abundant gas, and abundant white blood cells. This is the classic presentation of anaerobic cellulitis. It highlights the point made by MacLennan in his report that many cases of clostridial infection are not "gas gangrene" and do not require the kind of aggressive mutilating surgical treatment that true myonecrosis often demands. My personal experience includes two cases of local clostridial infection marked by abundant white blood cells and minimal systemic reaction and appropriately treated by local debridement and antibiotics. A third such case has been described to me. While antibody to the θ-toxin may well explain the findings in this case, physicians should be aware that localized clostridial soft tissue infections with an intact inflammatory response can occur primarily after injury and can be dealt with by a measured therapeutic response.

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Space Medicine Update

TO THE EDITOR: In the article on space medicine in the September 1987 issue,[1] my colleagues and I stated that the current record for continuous time in space was 236 days set by Soviet cosmonauts Kizim, Solovyov, and Atkov. Another Soviet cosmonaut, Yuri Romanenko, has shattered the old record by remaining in space for 326 days. Currently, Vladimir Titov and Musa Manarov are orbiting the earth aboard

the space station Mir. Whether they will attempt to spend an entire year in space remains to be seen.

As always, records exist to be broken.

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Medicine in the USSR

To the Editor: As Russian-speaking physicians who have just returned from seven months in the Soviet Union, we read Dr Friedenberg's overview of Soviet health care[1] with great interest. While we can corroborate many of the author's observations, we think that his conclusions understate the sorry condition of Soviet medicine.

There is ample documentation in the Western literature of the USSR's rising infant[2] and overall[3] mortality rates, of the decline in spending on health care that by one estimate now amounts to just 2% of the gross national product,[4] and of the technologic backwardness that characterizes most hospitals and clinics.[4] To this we would add that dissatisfaction with the poor quality and corruption of the health care system is widespread among both patients and physicians.

While the illegal practice of payment on the side to physicians and nurses—required simply to have one's operation done or one's medication given—is so prevalent that it has recently been acknowledged in the Soviet press (*Izvestia,* Sep 24, 1987), worse yet is the fact that many people are distrustful of the system at any price, official or unofficial. Physicians themselves complain about policies that stress quantity, not quality, low prestige and pay, and lack of professional autonomy. Professional input in health policy and public health is also lacking, as may be judged by recent measures that mandate human immunodeficiency virus testing for many groups and prison terms for those who deliberately expose another to the virus (*Izvestia,* Aug 26, 1987).

We commend Dr Friedenberg on his accurate reporting of many facets of the Soviet health care system and would emphasize the abysmally low level of care that is a fact of life for Soviet citizens.

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